

NORWALK - LA MIRADA UNIFIED SCHOOL DISTRICT

12820 Pioneer Blvd., Norwalk, CA 90650-2894

(562) 868-0431

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH AND/OR EDUCATIONALLY RELEVANT INFORMATION

Completion of this document authorizes the disclosure and/or use of individually identifiable health and/or educationally relevant information, as set forth below, consistent with California and Federal law concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization.

USE AND DISCLOSURE INFORMATION:

Student Name: _____
Last First MI D.O.B.

I, the undersigned, do hereby authorize (name of agency and/or health care providers):

(1) _____ (2) _____
to provide health and/or educationally relevant information from the above named child's record to:

School District to which disclosure is made Contact person and School/Department

Area Code/Telephone Number/Ext.

The disclosure of health and/or educationally relevant information is required for the following purpose:

Requested information shall be limited to the following:

All health information; or Disease specific information; or educational information as described:

DURATION:

This authorization shall become effective immediately and shall remain in effect until _____ (date) or for one year from the date of signature.

RESTRICTIONS:

California law prohibits the Requester from making further disclosure of my information unless the Requester obtains another authorization from me or unless such disclosure is specifically required or permitted by law.

YOUR RIGHTS:

I understand that I have the following rights with respect to this Authorization: I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the agencies/persons listed above. My revocation will be effective upon receipt, but will not be effective to the extent that the Requester or others have acted in reliance to this Authorization.

RE-DISCLOSURE:

I understand that the Requester (School District) will protect this information by the Family Equal Rights Protection Act (FERPA) and that the information becomes part of the student's permanent educational record. The information will be shared with individuals working at or with the School District for the purpose of providing safe, appropriate, and least restrictive educational settings and school health services and programs. I have a right to receive a copy of this Authorization. Signing this Authorization may be required in order for this student to obtain appropriate services in the educational setting.

APPROVAL:

Print Name Signature Date

Relationship to student Area Code/Telephone Number/Ext.